Physiotherapy Intake Form

Full Name:	Date:	
Contact No:	Age:	
Address:	City:	Postal Code:
Date of Birth: (DD/MM/YY)	Male/Female	Email:
Employer:	Occupation:	
Extended health Insurance Provider:		
Family Doctor Name	Number:	
Date of last Doctor Visit:	Reason:	
Is your condition due to: Car Accident	Workplace Injury?	Personal Injury?
Date of Injury	Any Medications?	
Are you currently seeing any other practitioners for your injury?		
Any previous surgeries or relevant medical history:		
Womens Health: Are you currently pregnant?		
Have you ever seen? Chiropractic Massage Therapy	Physiotherapy Shockwave	Acupuncture
How did you hear about this clinic?		
Emergency contact name:	Phone number:	

Privacy Policy: Personal health information is collected at Managed at Inklein Health Klinic in accordance with the Personal Health Information Protection Act (PHIPA). For more information please ask your health care provider or go to www.ipc.on.ca

Cancellation Policy: We appreciate 24 hours advance notice for any cancellations and reserve the right to charge a cancellation fee if not adhered to

- ❖ I hereby confirm that all information I have supplied is accurate and complete.

Signature _____
Date: _____

Please X the box for any conditions or symptoms presently causing you problems. Please check the box for those conditions or symptoms that you have had in the past

General Symptoms

- ☐ Loss of consciousness
- ☐ Blackouts
- ☐ Headaches
- ☐ Fever
- ☐ Excess sweating
- ☐ Night Sweats
- ☐ Loss of weight
- ☐ Night pain
- ☐ Generalized pain
- ☐ Nervousness
- ☐ Convulsion
- ☐ Loss of sleep

Neurologic

- ☐ Dizziness
- ☐ Fainting
- ☐ Problems speaking
- ☐ Problems swallowing
- ☐ Blurred vision
- ☐ Double vision
- ☐ nausea
- ☐ Clumsiness
- ☐ Numbness or tingling

Muscles and Joints

- ☐ Sore/stiff neck
- ☐ Mid back ache
- ☐ Low back ache
- ☐ Painful tailbone
- ☐ Shoulder pain
- ☐ Arm/forearm pain
- ☐ Elbow pain
- ☐ Wrist/hand pain
- ☐ Hip pain
- ☐ Knee pain
- ☐ Ankle/foot trouble
- ☐ Arthritis
- ☐ Loss of strength

Eyes/Ears/Nose/Throat

- ☐ Failing vision
- ☐ Eye pain
- ☐ Failing hearing
- ☐ Earache
- ☐ Ring/buzz in ears
- ☐ Frequent colds
- ☐ Sinus infection
- ☐ Enlarged Thyroid

Respiratory

- ☐ Asthma
- ☐ Chronic Cough
- ☐ Spitting of phlegm
- ☐ Splitting up blood
- ☐ Difficulty breathing

Cardiovascular

- ☐ Bleeding disorder
- ☐ High blood pressure
- ☐ Chest pain
- ☐ Stroke
- ☐ Hardening of arteries
- ☐ Varicose veins
- ☐ Swelling of ankles
- ☐ Poor circulation
- ☐ Heart/blood disease
- ☐ Angina

Genitourinary

- ☐ Trouble urinating
- ☐ Blood in urine
- ☐ Kidney infection
- ☐ Bedwetting
- ☐ Prostate trouble

GU for women

- ☐ Painful menstruation
- ☐ Excessive flow
- ☐ Hot flashes
- ☐ Irregular/absent cycle
- ☐ Cramping/backache
- ☐ Vaginal discharge
- ☐ Swollen breast
- ☐ Lump in breast

Currently are you on birth control pills/patch

yes no

Previously on birth control pills/ patch

yes no

# of pregnancies ____

# of children ____

Skin

- ☐ Rashes/itching
- ☐ Bruise easy
- ☐ Dryness
- ☐ Boils
- ☐ Hives (allergies)

Gastrointestinal

- ☐ Poor appetite
- ☐ Indigestion
- ☐ Excess hunger
- ☐ Belching or gas
- ☐ Vomiting
- ☐ Pain over stomach
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ Jaundice
- ☐ Gall bladder trouble
- ☐ Intestinal worms
- ☐ Ulcer
- ☐ Diabetes

Have you ever had any fractures?

yes no

If yes – where?

Do you have a pacemaker?

yes no

Have you ever been in a car accident?

yes no

If yes – when? _____

Have you ever been hospitalized?

yes no

Why/When? _____

Are you currently a smoker?

yes no

How much? _____

Did you smoke previously?

yes no

How much? _____

Have you ever been diagnosed:

With cancer? yes no

With aids? yes no

with HIV? yes no

Consent to Physiotherapy Treatment

I give my consent to undergo assessment and treatment. I have had the chance to discuss with my healthcare provider(s) the risks and benefits for my particular condition. My treatment may include: manual therapy, modalities (e.g. heat, ice, whirlpool, contrast bath, wax, laser, ultrasound, interferential current (IFC), electrical muscle stimulation, TENS, mechanical traction, acupuncture, dry needling, intramuscular stimulation, cupping, spinal manipulation), and active exercise. I understand that results are not guaranteed and that I may withdraw this consent at any time. If deemed appropriate by my therapist, I agree to have a student or support personnel carry out my treatment plan under supervision.

Name (Please Print)

Signature of patient (or legal guardian) Date:

Signature of Physiotherapist Date:

INKLEIN
HEALTH KLINIC

Inklein Health Klinic is a multidisciplinary clinic, which offers a wide array of potential care for all of your health concerns. If you would like to find out more about what your personal health insurance covers, please let us know and our staff will call for you to find out.

Insurance Company: _____

Service	Coverage Amount	% Coverage	Max per Treatment	Dr. Note
Physiotherapy				
Acupuncture				
Chiropractic				
Naturopath				
Massage				
Psychotherapy				
Orthotics				
Compression Hosiery				

Year End: _____

Spousal Secondary Coverage? _____